MDR Tracking Number: M5-04-2446-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution- General, 133.307 and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. This dispute was received on 04-05-04.

The Medical Review Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the issues of medical necessity. Therefore, the requestor is not entitled to reimbursement of the IRO fee. The therapeutic activities, therapeutic exercises, hot/cold pack therapy, and electrical stimulation rendered from 10/20/03 through 11/19/03 **were found** to be medically necessary. The therapeutic activities, therapeutic exercises, hot/cold pack therapy, and electrical stimulation rendered from 11/20/03 through 12/08/03 **were not** found to be medically necessary.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On July 29, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14 days of the requestor's receipt of the Notice.

- **CPT code 99214** for dates of service 11/03/03-11/07/03 was denied by the carrier with an "F" payment exception code (fee guideline reduction). However, no payment was rendered for this code. In accordance with Rule 134.202 (b) and (c)(1), reimbursement **is recommended** in the amount of $103.24.

- **CPT code 97530** for dates of service 11/03/03-11/07/03 was denied by the carrier with an "F" payment exception code (fee guideline reduction). However, no payment was rendered for this code. In accordance with Rule 134.202 (b) and (c)(1), reimbursement **is recommended** in the amount of $474.24.

- **CPT code 99361** for date of service 11/03/03 was denied by the carrier with an "F" payment exception code (fee guideline reduction). In accordance with Rule 134.202 (c)(6), "for products and services for which CMS or the commission does not establish a relative value unit and/or a payment amount, the carrier shall assign a relative value, which may be based on nationally recognized published relative value studies, published commission medical dispute decisions, and values assigned for services involving similar work and resource commitments." The requestor billed $53 for this service. However, no payment was rendered. Despite the request for additional information, the carrier did not submit documentation regarding relative values for this service. Since a relative value was not assigned by the carrier for this disputed service, reimbursement **is recommended** in accordance with Rule 134.202 (c)(6).

- **CPT code 97110** for dates of service 11/03/03-11/07/03 was denied by the carrier with an "F" payment exception code (fee guideline reduction). However, no payment was rendered for these codes. Recent review of disputes involving CPT Code 97110 by the Medical Dispute Resolution section as well as analysis from recent decisions of the State Office of Administrative Hearings indicate overall deficiencies in the adequacy of the documentation of this Code both with respect to the medical necessity of one-on-one therapy and documentation reflecting that these individual services were provided as billed. Moreover, the disputes indicate confusion regarding what constitutes "one-on-one." Therefore, consistent with the general obligation set forth in Section 413.016 of the Labor Code, the Medical Review Division has reviewed the matters in light all of the Commission requirements for proper documentation. The MRD declines to order payment because the SOAP notes do not clearly delineate exclusive one-on-one treatment nor did the requestor identify the severity of the injury to warrant exclusive one-to-one therapy. On this basis, reimbursement **is not** recommended.

- **CPT code 97540** for dates of service 11/03/03 and 12/4/03 and **CPT code 90830** for date of service 12/8/03 were deleted in 1998. Rule 134.202 (b) states: "for coding, billing, reporting, and reimbursement of professional medical services, Texas Workers Compensation system participants shall apply the Medicare program reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies in effect on the date a service is provided with any additions or exceptions in this section." Therefore, reimbursement **is not** recommended.

This Findings and Decision is hereby issued this 20th day of September 2004.

Regina L. Cleave
Medical Dispute Resolution Officer
Medical Review Division

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with Medicare program reimbursement methodologies per Commission Rule 134.202 (b) plus all accrued interest due at the time of payment to the requestor within 20 days of receipt of this order. This Order is applicable to the above dates of service outlined in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 20th day of September 2004.

Roy Lewis, Supervisor
Medical Dispute Resolution
Medical Review Division

June 28, 2004

NOTICE OF INDEPENDENT REVIEW DECISION

RE: MDR Tracking #: M5-04-2446-01
TWCC #:
Injured Employee:
Requestor:
Respondent:
------ Case #:

------ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The ------ IRO Certificate Number is 5348. Texas Worker's Compensation Commission (TWCC) Rule §133.308 allows for a claimant or provider to request an independent review of a Carrier's adverse medical necessity determination. TWCC assigned the above-reference case to ------ for independent review in accordance with this Rule.

------ has performed an independent review of the proposed care to determine whether or not the adverse determination was appropriate. Relevant medical records, documentation provided by the parties referenced above and other documentation and written information submitted regarding this appeal was reviewed during the performance of this independent review.

This case was reviewed by a practicing chiropractor on the ------ external review panel who is familiar with the with the condition and treatment options at issue in this appeal. The reviewer has met the requirements for the ADL of TWCC or has been approved as an exception to the ADL requirement. The ------ chiropractor reviewer signed a statement certifying that no known conflicts of interest exist between this chiropractor and any of the treating physicians or providers or any of the physicians or providers who reviewed this case for a determination prior to the referral to ------ for independent review. In addition, the ------ chiropractor reviewer certified that the review was performed without bias for or against any party in this case.

Clinical History

This case concerns a female who sustained a work related injury on ------. The patient reported that while at work she sustained a repetitive motion injury to her back after repeatedly moving inventory from the stock room to her sales area in the store. A MRI of the lumbar spine performed on 10/30/03 revealed degenerative facet hypertrophy, milt to moderate severity at L4-5 and to a mild degree, L3-4, mild degenerative disc bulge approximately 3mm in magnitude, and no focal nerve root impingement or significant spinal stenosis. The diagnoses for this patient have included lumbar disc displacement, lumbar sprain/strain, and cervical sprain/strain. The initial treatment for this patient included passive modalities consisting of chiropractic manipulation, electrical muscle stimulation and massage for active trigger points in the lumbar spine. The patient was then referred to the treating chiropractor where she began active physical medicine and rehabilitation therapy.

Requested Services

Therapeutic activities, therapeutic exercises, hot/cold pack therapy, electrical stimulation from 10/20/03 through 12/8/03.

Documents and/or information used by the reviewer to reach a decision:

Documents Submitted by Requestor:

1. Position paper 5/24/04
2. Chiropractic Modality Review 12/4/03
3. Initial Medical Report 10/9/03
4. Progress notes 10/20/03 – 11/3/03
5. Office notes 11/11/03 – 12/12/03

Documents Submitted by Respondent:

1. Peer Review 11/18/03
2. Chiropractic Modality Review 12/4/03
3. Office notes 9/15/03 – 11/3/03

Decision

The Carrier's determination that these services were not medically necessary for the treatment of this patient's condition is partially overturned.

Rationale/Basis for Decision

The ------ chiropractor reviewer noted that this case concerns a female who sustained a work related injury to her back on ------. The ------ chiropractor reviewer also noted that the diagnoses for this patient have included lumbar disc displacement, lumbar sprain/strain, and cervical sprain/strain. The ------ chiropractor reviewer further noted that treatment for this patient's condition has included chiropractic manipulation, electrical muscle stimulation, massage for active trigger points, active physical medicine and rehabilitation therapy. The ------ chiropractor reviewer explained that if after 6-8 weeks of conservative care the patient showed objective and subjective improvement, further care would be required. However, the ------ chiropractor reviewer indicated that this patient's condition plateaued. The ------ chiropractor reviewer noted that the patient was then sent for facet injections on 11/19/03. The ------ chiropractor reviewer also indicated that the patient responded better to the facet injections than the conservative care. The ------ chiropractor reviewer explained that treatment up until 11/19/03 appeared to be beneficial for the patient. However, the ------ chiropractor reviewer also explained that conservative care after 11/19/03 was not documented as being beneficial for this patient's condition. Therefore, the ------ chiropractor consultant concluded that the therapeutic activities, therapeutic exercises, hot/cold pack therapy, electrical stimulation from 10/20/03 through 11/19/03 were medically necessary to treat this patient's condition. The ------ chiropractor consultant further concluded that the therapeutic activities, therapeutic exercises, hot/cold pack therapy, electrical stimulation from 11/20/03 to 12/8/03 were not medically necessary to treat this patient's condition.

Sincerely,